Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN3867AGC	A. BUILDING _____ B. WING _____	07/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS CASTLE HOME CARE	2060 ARCANE AVE RENO, NV 89503

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Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 7/30/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 070 SS=E	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility did not ensure 1 of 3 caregivers had received at least eight hours of annual training. Findings include: The administrator, Employee #2, had evidence of 6.75 hours of annual training in his facility file. This was a repeat deficiency from the 7/12/07 annual State Licensure survey.	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 070	Continued From page 1 Severity: 2 Scope: 2	Y 070		
Y 105 SS=B	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility did not ensure 1 of 3 employees had complete evidence for a background check. Findings include: Employee #3 was hired in June of 2005. Fingerprint cards dated 7/31/06 were in her facility file along with FBI background check results. The file did not contain State of Nevada background check results. Severity: 1 Scope: 2	Y 105		
Y 175 SS=E	449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility.	Y 175		

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Y 175	Continued From page 2 This Regulation is not met as evidenced by: Based on observation and interview on 7/30/08, the facility did not ensure adequate equipment was provided for safe bathroom transfers for 2 of 6 residents. The facility was not free of hazards. Findings include: 1. A bathroom complete with a toilet and tub/shower combination was located in the hallway in the middle of the house. The bathroom had a narrow, galley type set up with the sink cabinet and toilet on the west wall and the tub/shower next to the toilet on the south wall. Caregivers reported they used this hall bathroom for the showering of residents. After observing the bathroom used for showering residents, Resident #4 and the caregivers were asked about the ease of transfers of the resident to the toilet and shower chair. Resident #4 is a wheelchair bond male resident with a history of rheumatoid arthritis (RA) and with secondary joint deformity. The resident and the caregivers reported the resident needed full assistance with transferring from his bed to a wheelchair; wheelchair to the toilet and wheelchair to a shower chair. The resident reported he was no longer able to scoot himself across the slide board used for transfers from his bed to the wheelchair and from his wheelchair to the shower chair. The hall bathroom toilet was provided with U-shaped handlebars that were attached to the toilet base. The arms of the unit were not movable. Resident #4 and the caregivers reported they had difficulty with transferring the resident from his wheelchair to the toilet due to the narrowness of the bathroom and because the location of the toilet handlebars. The arms of the toilet handlebars could not be lifted upward to	Y 175		

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Y 175	Continued From page 3 allow the resident to be slid from his wheelchair to the toilet, so the resident had to be lifted to a standing position, pivoted and lower to the toilet seat. The caregivers spoke of concern that they might drop the resident and the physical strain of lifting and lowering the resident. The resident reported his discomfort level increased during the lifting and lowering to the toilet. The caregivers and the resident reported a toilet handlebar system with movable arms would make this transfer easier. The hall bathroom shower was in a traditional bathtub which required Resident #4 to be transferred from his wheelchair to a shower chair. The resident and caregivers reported they also had difficulty with transferring the resident for his showers due to the narrowness of the bathroom, the toilet handlebars and the side of the bathtub. The caregivers reported the slide board used for the bed transfers was not long or large enough to safely use it between the wheelchair and the shower chair. Therefore, the resident had to be lifted out of his wheelchair, pivoted, and lowered into the shower chair which was difficult for both the resident and the caregivers. The caregivers and resident reported a larger slide board, or a shower chair slide board combination would make this transfer easier. The caregivers reported they had the same transfer issues with Resident #1 who was also wheelchair bound. 2. A recliner chair was located in the bedroom of Resident #2. The chair included an electrical lift to assist the resident with standing and transfers. The toggle switch hand control was missing its plastic case and was wrapped in red electrical tape and the spiral, rubber wiring tube was pulled away from the hand control leaving several inches of plastic coated wiring exposed.	Y 175		

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Y 175	Continued From page 4 3. There was an accumulation of dust and lint on the hoses, wiring and wall behind the dryer. Severity: 2 Scope: 2	Y 175		
Y 272 SS=B	449.2175(3) Service of Food - Menus NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days. This Regulation is not met as evidenced by: Based on record review and interview on 7/30/08, the facility did not ensure its menus were dated and kept for 90 days. Findings include: A menu for the current week was posted in the hallway of the facility. The caregiver was unable to provide dated menus for the last 90 days. Severity: 1 Scope: 2	Y 272		
Y 870 SS=C	449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Administration NAC 449.2742 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility:	Y 870		

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Y 870	Continued From page 5 (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident. This Regulation is not met as evidenced by: Based on record review and interview on 7/30/08, the facility did not ensure medication reviews were being completed every six months on 6 of 6 residents who had lived at the facility for longer than six months. Findings include: Review of the files for Residents #1, #2, #3, #4, #5 and #6 revealed medication regimen reviews were not being completed every six months as required. The administrator reported he did not have an arrangement to ensure the reviews were completed. Severity: 1 Scope: 3	Y 870		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:	Y 878		

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Y 878	Continued From page 6 (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility did not ensure 1 of 6 residents received an over the counter (OTC) medication as prescribed. Findings include: Resident #2 was prescribed Oscal, an OTC supplement containing 500 mg of calcium and 20 IU of Vitamin D by his physician. A bottle of Citracal was being used instead of the Oscal and the caregiver reported the Citracal was delivered to the facility by the resident's family. The Citracal contained 630 mg of calcium and 400 IU of Vitamin D, a dosage different than what was prescribed by his physician. Severity: 2 Scope: 1	Y 878		
Y 885 SS=E	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials,	Y 885		

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Y 885	Continued From page 7 bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on observation and interview on 7/30/08, the facility did not ensure expired medications and medications of discharged residents were destroyed. Findings include: A cabinet in the kitchen was being used to store resident medications. Knotted bags containing pill bottles were noted in the far back and side of the cabinet. The bags contained expired medications for Resident #4 and medications for two discharged residents. There was also an unlabeled bubble pack of Acetaminophen 500 mg tablets with an expiration date of February 2007. Severity: 2 Scope: 2	Y 885		
Y 936 SS=E	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of	Y 936		

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Y 936	Continued From page 8 chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility did not ensure 1 of 6 residents met the requirements for initial tuberculosis (TB) testing. Findings include: Resident #3 was admitted on 1/7/08 and completed a one-step TB test on 12/1/07. The second step was initiated on 12/8/07 but there was no documentation that it was read. There was a negative chest x-ray in the file dated 4/10/08 but no evidence the resident had tested positive for TB to warrant the chest x-ray. The resident needs to complete another one-step TB test to be in compliance with the requirement. This was a repeat deficiency from the 7/12/07 annual State Licensure survey. Severity: 2 Scope: 2	Y 936		
Y 944 SS=A	449.2749(2) Resident File / Discharge NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to inform him of the death.	Y 944		

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Y 944	Continued From page 9 This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility did not ensure discharge information was available in the file for 1 of 1 discharged resident. Findings include: A file for discharged Resident #7 was provided by the caregiver for review. The file did not contain any information concerning the discharge of the resident. Severity: 1 Scope: 1	Y 944		
YA645 SS=A	449.2704(1-5) Rate Agreement NAC 449.2704 The administrator of a residential facility shall, upon request, make the following information available in writing: 1. The basic rate for the services provided by the facility; 2. The schedule for payment; 3. The services included in the basic rate; 4. The charges for optional services which are not included in the basic rate; and 5. The residential facility's policy on refunds of amounts paid but not used. This Regulation is not met as evidenced by: Based on record review on 7/30/08, the facility	YA645		

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YA645	Continued From page 10 did not ensure 1 of 6 residents had a current rate agreement in the facility file. Findings include: Resident #1 was admitted on 1/10/04 and the rate agreement indicated it was for a respite period of two weeks. The administrator reported the resident continued to live at the facility after the respite period but there was no rate agreement in the resident's file dated for when the resident became permanent. Severity: 1 Scope: 1	YA645		